	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Document Code: HSAAS/UKA/BR227**
	FITNESS FOR WORK FORM

Employee Section (This section must be completed and signed by the patient to authorize the release of medical information)

Name:	
Identification No:	
Staff No:	
Work Placement:	
First day of work:	
Last day of work (if applicable)	

Signature:

Date:

General Information (if applicable)

First date unable to work in full capacity:	
Reason for the above issue:	
Duration of MC/light duty given:	
Return to work date:	

Work Restrictions (If applicable)

Estimated Duration of Restrictions:

☐ Days ☐ 2-4 weeks ☐ 4-6 weeks ☐ 6-8 weeks ☐ 8-10 weeks

☐ Temporary ☐ Permanent

Next Follow-Up:

☐ Yes, Date:

☐ No

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SPECIFIC FUNCTIONAL RESTRICTION AND/OR LIMITATIONS

To be completed by Attending Physician

Patient's Name: _____

Check only those items that apply in Section A. Only tick where applicable.

Provide details in Section B.

Section	**Restriction**	**Limitation**		**Restriction**	**Limitation**
Physical	☐	☐	**Mental**	☐	☐
Sitting	☐	☐	Thinking/reasoning	☐	☐
Standing	☐	☐	Concentration	☐	☐
Walking	☐	☐	Memory	☐	☐
Lifting	☐	☐	Critical decision making	☐	☐
Carrying	☐	☐	Alertness	☐	☐
Pushing/Pulling	☐	☐	Other (specify in Section B)	☐	☐
Climbing Stairs	☐	☐	**Environmental**	☐	☐
Climbing Scaffolding	☐	☐	Exposure to heat/cold	☐	☐
Crouching	☐	☐	Exposure to dust/fumes/odors	☐	☐
Crawling	☐	☐	Exposure to chemicals	☐	☐
Kneeling	☐	☐	Food handling	☐	☐
Bending/twisting/turning	☐	☐	Other (specify in Section B)	☐	☐
Repetitive activity	☐	☐	**Others**	☐	☐
Sustained postures	☐	☐	Shift/ Attendance duration	☐	☐
Gripping	☐	☐	Consecutive shift duration	☐	☐
Reaching	☐	☐	Shift work	☐	☐
Fine Dexterity	☐	☐	Overtime	☐	☐
Balance	☐	☐	Operating a vehicle	☐	☐
Vision/hearing/speech	☐	☐	Working at heights	☐	☐
Other (specify in section B)	☐	☐	Other (Specify in Section B)	☐	☐

Does the patient require medical aids? (splint, brace or personal protective equipment etc.)

☐ Yes ☐ No (specify in Section B)

Section B

Please provide quantitative details regarding limitations.

_____

_____

Section C (Tick if the patient fit)

☐ No Functional Restriction/Limitation

Restrictions: Patient advised not to perform this activity in any capacity.

Limitations: Patients able to perform the activity in reduced capacity.

All limitations must be quantified in Section B.

FITNESS FOR WORK CERTIFICATE

Named of Person examined:

NRIC/Passport No.:

Name and address of Employer:

_____

_____

_____

I hereby certify that I have examined the above named person on _____ from the information related to health being declared by the person, my clinical examination and diagnostic tests, I certify that this worker is

☐ FIT
☐ NOT FIT
☐ FIT FOR MODIFIED DUTIES

Doctor's signature:
Name of OHD:
DOSH RN:
Name of hospital:
Date: